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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **NERISSA MANALO VALDEZ aka** **NERISSA GENILO MANALO** **61 Plaza Avila** **Lake Elsinore, CA 92532** **Registered Nurse License No. 338580** Respondent.	Case No. 2013-395 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about November 30, 1981, the Board of Registered Nursing issued Registered Nurse License Number 338580 to Nerissa Manalo Valdez aka Nerissa Genilo Manalo (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY AND REGULATORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions...

7. Title 16, California Code of Regulations, section 1442, states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

8. Title 16, California Code of Regulations, section 1443, states:

> As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. Title 16, California Code of Regulations, section 1443.5 states:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:
>
> (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
>
> (2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
>
> (3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.
>
> (4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.
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> (5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.
>
> (6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

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FACTS

11. Respondent was employed as a Registered Nurse in the Progressive Care Unit of Inland Valley Regional Medical Center ("Hospital") on June 18, 2010 and worked the day shift, which was from 0700 hours to 1900 hours.

12. Patient was an 81-year old female who was admitted to the Hospital on June 14, 2010 with chest tightness and atrial fibrillation. An MRI on June 14, 2010 showed an acute infarction in the brain.

13. Registered Nurse, R.M. was the nurse on duty during the night shift on June 17, 2010 and was Patient's nurse. On June 18, 2010, at about 0700 hours, R.M. gave a change-of-shift report to Respondent about Patient. Respondent assumed the care of Patient at 0700 hours on June 18, 2010, as well as two other patients. R.M. advised Respondent that Patient was "in atrial fibrillation", among other things, and that there were no concerns or urgent matters regarding Patient's health. At this time, Patient was alert and oriented.

14. At 0800 hours, Respondent performed an initial assessment of Patient. Respondent documented that Patient was awake and alert and that her speech was clear and appropriate. The Patient's vital signs were taken and no irregularities were noted.

15. Two hours later, at 1000 hours, Patient's family advised Respondent that they noticed changes in Patient's vision in that she had "difficulty focusing on things like wall clock". Respondent also noted that Patient had "sl[ight] difficulty expressing." Despite Patient's change in status, there was no documentation that Respondent took Patient's vital signs or that Respondent performed a neurological examination. Respondent contacted Patient's doctor, Dr. K. to inquire about a low potassium level but there is no documentation that Respondent notified Dr. K. about the change in Patient's neurologic status.

16. At 1200 hours, Respondent took Patient's vital signs, which were without significant change. Other nursing assessments were also documented as unchanged, however there is no documentation of a more in depth neurologic assessment. Patient's family asked to speak with Dr. K. about the patient's condition. Respondent notified Dr. K. and stated he would see the patient in a couple of hours, at about 1400 hours.

17. At 1400 hours, Respondent documented that Patient "appeared more confused and having problems expressing herself." Dr. K. ordered a CT scan of Patient's brain and discussed Patient's condition with her family. A CT scan was performed at about 1500 hours. The results were reported at 1545 hours showing evidence of intracranial bleed. Dr. K. ordered Vitamin K and Fresh Frozen Plasma ("FFP"), with approval from the hematologist (Dr. M.) and the cardiologist (Dr. C.).

18. Dr. S. and Dr. C. had offices outside the Hospital. According to Respondent, telephone calls were placed, and messages left, by a secretary to Drs. S. and C. There is no documentation regarding when the doctors were called, how many times they were called or if they responded.

19. The patient's vital signs were generally unchanged at 1600 hours with a slight decrease in oxygen saturation and a decrease in the Glasgow Coma Score to 14 from 15 at 0800 hours and 1200 hours. At about 1635 hours, Respondent spoke with Dr. C. on the telephone and got approval to administer Vitamin K and FFP. At 1630 hours Dr. M. deferred to another doctor due to insurance coverage issues. That doctor was not paged until two hours later, at 1840 hours. At 1900 hours, a telephone order was noted for the administration of vitamin K and FFP. At 1900, Respondent transferred care of Patient to R.M.

20. R.M. received a change-of-shift report from Respondent regarding Patient at 1930 hours. Respondent advised R.M. that Respondent ordered the vitamin K from the pharmacy and FFP from the blood bank but the medication had not yet been delivered to the Progressive Care Unit. After R.M. assumed care of Patient, she noticed her condition had changed since R.M.'s last shift. Patient appeared confused and disoriented. The vitamin K was not received until after 2000 hours. R.M. administered it at 2000 hours. At 2300 hours, FFP was delivered. However, before administering it to Patient, R.M. contacted the rapid response team because she found Patient unresponsive in her room. The FFP was administered at 2305 hours. However, Patient's condition deteriorated and she was pronounced dead at 0335 hours on June 19, 2010.

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Gross Negligence In Failing to Notify Physician of Change of Status of Patient)

21. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross negligence, as defined in title 16, California Code of Regulations, section 1442, in that Respondent failed to notify a physician of the change in her patient's status, which constitutes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse, as more fully set forth in paragraphs 11-20 and incorporated herein as though set forth in full.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Gross Negligence In Failing to Administer Medication As Ordered)

22. Respondent is subject to disciplinary action under Code section 2761(a)(1) for gross negligence, as defined in title 16, California Code of Regulations, section 1442, in that Respondent failed to follow through with carrying out a physician's orders for treatment and failed to notify the primary physician of the lack of response or inability to contact the requested physicians, and which resulted in a delay of care, which constitute an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse, as more fully set forth in paragraphs 11-20 and incorporated herein as though set forth in full.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Incompetence for Failing to Notify Physician)

23. Respondent is subject to disciplinary action under Code section 2761(a)(1) for incompetence, as defined in title 16, California Code of Regulations, section 1443, in that Respondent failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse when she failed to notify a physician of the change in her patient's status, as more fully set forth in paragraphs 11-20 and incorporated herein as though set forth in full.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Incompetence for Failing to Administer Medication as Ordered)

24. Respondent is subject to disciplinary action under Code section 2761(a)(1) for incompetence in that Respondent failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse when she failed to follow through with carrying out a physician's orders for treatment and failed to notify the primary physician of the lack of response or inability to contact the requested physicians, resulting in a delay of care, as more fully set forth in paragraphs 11-20 and incorporated herein as though set forth in full.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

25. Respondent is subject to disciplinary action under Code section 2761(a) for unprofessional conduct in that Respondent failed to notify a physician of the change in her patient's status, failed to follow through with carrying out a physician's orders for treatment and failed to notify the primary physician of the lack of response or inability to contact the requested physicians, resulting in a delay of care, as more fully set forth in paragraphs 11-20 and incorporated herein as though set forth in full.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 338580, issued to Nerissa Manalo Valdez;

2. Ordering Nerissa Manalo Valdez aka Nerissa Genila Manalo to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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3. Taking such other and further action as deemed necessary and proper.

DATED: November 14, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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